Remarks

The final office action dated November 28, 2006 has been received and its contents carefully noted.

Claims 1-18 are pending in the application.

Claims 1-18 are rejected by the Examiner.

Applicant has amended some of the claims as set forth above and has carefully considered the arguments advanced by the Examiner and respectfully requests favorable reconsideration based on the above amendments and following comments which are trusted to be persuasive in bringing about allowance of the application at an early date.

Applicant's Invention

Applicant's invention as disclosed and claimed provides a rules-based system (RBS) independent of any database resident at the insurance companies system or third party processor of Employer sponsor health plans.

Applicant's invention as disclosed and claimed relies on the insurance company's clinical policy and health industry clinical information for carrying out the operational features and advantages of its RBS system.

As set forth in independent claim 1, Applicant's invention specifies:

generating a patient benefits plan at the service provider/medical facility location as defined by provisions for payment coverage under a corresponding contract for the patient.

The ability to generate a patient's benefit plan under the contract is an important and unique feature of Applicant's invention that is not taught, disclosed or suggested in the art. Health care benefit plans are defined by provisions of a contract for insurance coverage;

benefit plans define medical services that are payable under the contract;

the benefit plan defines benefit plan limitations, such as, for example, physical therapy visits being limited to either a dollar amount or by the number of visits per benefit year;

the benefit plan defines medical services that are not covered under the provisions of the contract; and

the benefit plan provides a schedule of coverage and reimbursements that is available under the benefit plan.

As set forth in independent claim 1, Applicant's invention specifies:

defining the treatments and conditions of the patient claim for benefits under the contract;

Applicant's invention as disclosed and claimed builds a patient's benefit plan by mapping the CPT codes and the ICD-9 codes and any other claim data and EOB data to the patient's benefit plan to define the provisions under the benefit plan.

As set forth in independent claim 1, Applicant's invention specifies:

analyzing the patient claim for benefits for generating a preliminary Explanation-Of-Benefits (EOB) prior to submission for payment by a designated payor and for determining medical necessity protocols as defined by the patient benefit plan and Policy-Issuing-Company (PIC) standards;

Once the benefit plan provision(s) is defined, Applicant's invention pre-adjudicates claim information against the benefit plan that is issued by an insurance company or payer.

Applicant's invention as disclosed and claimed updates itself when EOB's are issued by the insurance company or payer, while at the same time validating the information in the insurance company or payer EOB against the benefit plan profile. Applicant's invention builds the insurance company's adjudication logic and it emulates the insurance company's or payer logic without any connectivity to the benefit plan issuing company.

Applicant's invention is a dynamic, rules based engine that updates itself based on results during the pre-adjudication of a claim and it compares the pre-adjudicated claim results (the preliminary EOB) against the corresponding EOB issued by the insurance company or payer (the PIC-generated EOB). The details to the pre-adjudication process are recorded in what the applicant's invention defines as the preliminary EOB.

As set forth in independent claim 1, Applicant's invention specifies:

verifying compliance of treatments and conditions in the patient claim for benefits with applicable standards;

The preliminary EOB is the equivalent to the insurance company's or payer's EOB (the PIC-generated EOB). The PIC-generated EOB is generated after the claim for benefits has been processed by the insurance company or payer. In Applicant's invention the preliminary EOB is generated prior to the submission of the claim for benefits to the insurance company or payer. Any disparity in the information between Applicant's preliminary EOB and the insurance company or payer EOB (the PIC-generated EOB) is recorded by Applicant's RBS system and updated accordingly.

As set forth in independent claim1, Applicant's invention specifies:

predetermining monetary allowance for medical services rendered based upon applicable payment schedules;

Applicant's invention is able to predict what an insurance company or payer will do when it processes the insurance claims against the benefit plan issued by the insurance company or payer. The ability and capability of Applicant's invention to predict the patient's benefit plan provisions and the insurance company's or payer's adjudication logic corresponds to and means the same thing as "emulating the insurer's adjudication process."

As set forth in independent claim 1, Applicant's invention specifies:

submitting the pre-adjudicated patient claim for benefits to ~~a~~ the designated payer in accordance with the patient benefit plan.

Applicant's invention emulates the adjudication process of any insurance company; of any government sponsored benefit plan such as for example, Medicare and Medicaid, and of any payer including self-funded benefit plans such as those administered by third party administrators. Applicant's invention is an all payer pre-adjudication and re-adjudication process not found, taught, disclosed or suggested in the art.

Claim Rejections 35 U.S.C. §§ 102 and 103

Claims 1-4 and 9-18 stand rejected under 35 U.S.C. §102(e) as being completely anticipated by the Provost et al. U.S. Patent No. 6,341,265.

Claims 5-8 are rejected by the Examiner under 35 U.S.C. 103(a) as being unpatentable over Provost et al. in view of Doyle et al. U.S. Patent No. 4,916,611.

The Examiner argues Provost teaches all the structural limitations of the claimed invention as the basis for the rejection. The prior art cannot anticipate the claim if there is any structural difference. It is well settled that a single prior art reference anticipates a patent claim if it expressly or inherently describes each and every limitation as set forth in the patent claim. Inherent anticipation requires that the missing descriptive material is "necessarily present," not merely, probably or possibly present, in the prior art.

Applicant respectfully disagrees with the rejection of the claims as being anticipated by Provost for at least the following cogent reasons.

Provost is at best a payer of benefit plans, technically referred to as a third party administrator (TPA). The processing of patient eligibility and other details is based on a self-funded benefit plan that is issued by the employer. In this case, the employer hires someone or organization such as a TPA to administer the benefit plan in his behalf. Applicant submits Provost does not have and lacks the operative capability to issue EOB's for insurance companies' or other payers and only has the operative capability to issue EOB's for self insured benefit plans that are defined by the employer.

Provost's administration of benefit plans uses a claim creation system (col. 6, lines 2-6), that creates a claim from the displayable claim diagnosis codes and treatment codes that are entered by a medical technician. The medical technician is permitted to enter multiple diagnosis codes describing the diagnosis of the patient and one or more treatment codes (col. 3,line 66 to col. 4, line 4). The medical technician can amend the treatment code or any other desired information on the insurance claim to place the claim in condition for payment (col. 6, lines 12-21). The actions of the medical technician are best guesses at which codes should be entered and are not based on any rules based adjudication process.

It is well recognized by an ordinary person in the art that Provost is nothing more than claim capturing or claims scrubbing system that is restricted to treatment codes and diagnosis codes and that these codes have predefined definitions and coding conventions in the public domain.

For example:

Diagnosis codes are issued and defined by the Center of Disease – Federal Government; The diagnostic codes are defined, and include coding guidelines and conventions within the International Classification of Disease version 9 (commonly referred to as ICD-9 codes).

Treatment codes are defined by the American Medical Association (AMA). The treatment codes, documentation guidelines, and coding edits are defined in the AMA's CPT (common procedural terminology) database.

ICD-9 diagnostic codes and CPT codes have been part of the public domain for over 30 years. Federally mandated regulations recognize ICD-9 and CPT codes to be part of the HIPAA regulations. ICD-9 and CPT codes are the data set standards for the health insurance industry.

Provost relies exclusively on these diagnosis codes and treatment codes to determine if the claim is in a condition to be paid (col.3 lines 24-30; col. 5, line 66 to col. 6, line 6, 12-21; col. 6, lines 2-11 and col.9, lines 53-58).

The central processing system of Provost operates as a claim capturing system that verifies that the physician, patient, and insurer are included in the claim form (col. 2, lines 3-10).

The central processing system converts the medical insurance claim into the appropriate format. Upon adjudication and approval of the insurance claims by the insurer, the insurer issues a check. When the insurer issues a check it attaches the insurer's (EOB) explanation of benefit.

Provost does not generate a preliminary EOB. Provost issues the insurer's EOB in response to the claim details that it receives. The central processing system in Provost does not emulate the insurer's adjudication process, and therefore lacks the operative capability to generate a preliminary EOB prior to issuing the insurer's EOB.

Provost's adjudication of the claim details is based on the benefit plan it is administrating for the employer and is not based on the insurer's adjudication process. Provost does not even suggest the usage of the insurer's adjudication process nor would one be motivated to modify Provost to use the insurer's adjudication process because such modification even if it could be made would change the operation and intent of Provost.

Validating the treatment codes and diagnosis codes in Provost is nothing more than knowing if the codes reported on the claim are outdated or consistent with predefined coding conventions that are part of the public domain. By correcting an invalid code the claim is made more accurate and eligible to be paid only because the code is correct and not because the claim has been adjudicated to insure qualification for payment under the provisions for coverage under the contract.

For example, Aetna's clinical policy defines chronic pain as having pain for three consecutive months the ICD-9 code-diagnosis code- 338.21 is used to report the term "chronic pain". Reporting ICD-9 code on the claim less then 338.21 would be denied because the treatments rendered were premature since the treatments were rendered prior to three months, as required by Aetna. The ICD-9 338.21 may be correct, however, not payable. Provost would have indicated the claim was in condition for payment when in fact it would not be paid.(col. 6, lines 12-21). In contrast, Applicant's RBS system as disclosed and claimed would indicate prior to the submission to and rejection by Aetna of the claim for benefits that the claim for benefits would not be paid.

In a further example, Aetna and Cigna consider treatment code 76085 to be experimental and investigation and the determination is based on evidence based medicine. The American Medical Association refers to CPT code – treatment code- 76085 to be an add-on procedure to mammography tests. These definitions are very different. Aetna and Cigna's adjudication process would have denied the service because they deemed it not medically necessary while the

AMA CPT database renders a definition of the code. Provost would have indicated the claim was in condition for payment when in fact it would not be paid (col. 6, lines 12-21). In contrast, Applicant's RBS system as disclosed and claimed would indicate prior to the submission to and rejection by Aetna and Cigna of the claim for benefits that the claim for benefits would not be paid.

In Provost, it is only when and after the claim for benefit is submitted to the insurance company that the insurance company adjudicates the claim based on its adjudication intelligence, and business rules, including clinical polices that it is learned that the claim for benefit might or might not be paid.

The adjudication process in Applicant's invention as disclosed and claimed goes beyond processing treatment codes AMA CPT codes or the governments ICD-9 disease classification but rather incorporates the necessary audit and fraud and abuse triggers issued by the insurer and further includes, but it is not limited to other resources within the health insurance industry.

Provost's method and system for interactively creating and submitting insurance claims and determining whether the submitted claims are in a condition for payment by an insurer does not include the insurer's adjudication process or considerations of insurer specific or health insurance health data. Upon adjudication and approval of the insurance claims by the insurer the insurer issues a check. It is only at the time when the insurer issues a check that the insurer attaches an (EOB) explanation of benefit and it is only then that the patient and the provider of the benefit learn whether the claim for benefits will or will not be paid.

Provost does not teach, disclose or suggest carrying out the insurer's adjudication process to pre-adjudicate the patient's claim for benefits as disclosed and claimed by Applicant's invention. Accordingly, Provost is deficient with respect to at least this element of independent claims 1, 16 and 18.

Provost is technically and operationally unable to issue a preliminary (EOB) explanation of benefit prior to the submission of the claim for benefits to the insurance company or payer.

Provost is inoperative with respect to this aspect of Applicant's invention. Provost does not teach, disclose or suggest issuing a preliminary EOB as disclosed and claimed by Applicant's invention. Accordingly, Provost is deficient with respect to at least this element of claim 1, 16 and 18.

Additionally, Provost does not process insurer data that is reflected in the insurer's EOB, and consequently does not teach, disclose or suggest processing insurer data that is reflected in the insurer's EOB to pre-adjudicate the patient's claim for benefits. Accordingly, Provost is deficient with respect to at least this element of independent claim 1, 16 and 18.

Provost does not submit a pre-adjudicated claim to a designated payer in accordance with the patient benefit plan because it does not include the insurer's adjudication process for analyzing the patient claim for benefits. Provost does not teach, disclose or suggest submitting a pre-adjudicated claim to a designated payer in accordance with the patient benefit plan because it does not include the insurer's adjudication process and is therefore inoperative with respect to this aspect of Applicant's invention. Accordingly, Provost is deficient with respect to at least this element of independent claim 1, 16 and 18.

Applicant submits that Provost is limited to being a payer of claims for self-funded contracts that are issued by employers and there is no fair basis for implying that an ordinary person in the art would arrive at Applicant's invention from the teachings of Provost, mush less that each and every element of Applicant's invention as claimed is found or disclosed by Provost.

Applicant submits that claims 1-4, 9-18 are not anticipated by Provost et al. U.S. Patent No. 6,341,265 and requests allowance of these claims for at least the above reasoning.

Claims 2-4, 9-15 and 17 are dependent directly or indirectly on independent claims 1 and 16 and it is submitted that these claims are likewise distinguishable over Provost for similar reasoning and for further limitations clearly set forth therein and not found in the independent claims and likewise requests allowance of these claims.

Accordingly, it is submitted that the present invention as claimed is readily distinguishable from the prior art references for the reasons indicated. Applicant's invention is not disclosed by any of the prior art and there is no fair basis for alleging that Applicant's invention is obvious in regard to such prior art. If the invention were obvious, it would have been adopted before in view of its advantages.

Conclusion

Applicant submits that all the claims of the application are now in condition for allowance and earnestly solicits such action at an early date. The Examiner is invited to call Applicant's attorney if any questions remain following review of this response.

Respectfully submitted,

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